VACCINE ADMINISTRATION RECORD

NORTH DAKOTA DEPARTMENT OF HEALTH
SFN 18385 (08-2015)

Provider ID:

Information collected on this form will be used to document authorization for receipt of vaccine(s). Information may be shared through the North Dakota Immunization Information System (NDIIS) with other entities in accordance with North Dakota Century Code 23-01-05.3.

Patient's name: (Last, First, Middle)			**Race: (Check box)**
			☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White
Hispanic or Latino: (Circle) Yes No	**Date of birth:**	**Age:**	**Gender (Circle):** Male Female
Address: (Street or P.O. box)			

City:	**State:**	**Zip code:**	**County:**	**Birth state or birth country (if not U.S.):**

Primary telephone number:	**Work telephone number:**	**E-mail address:**

Mother's name (if patient is 18 years or younger): Last, First, Middle	**Mother's maiden name (if patient is 18 years or younger):**

A copy of the appropriate Centers for Disease Control and Prevention Vaccine Information Statement(s) has been provided. I have read, or have had explained, the information about the disease(s) and the vaccine(s) listed below. There was an opportunity to ask questions and all questions were answered satisfactorily. I believe that I understand the benefits and risks of the vaccine(s) cited, and ask that the vaccine(s) listed below be given to me or to the person named above (for whom I am authorized to make this request).

Signature – Person to receive vaccine or person authorized to sign on the patient's behalf:	**Date:**

VFC eligibility status: (Check all that apply)
☐ American Indian ☐ Medicaid-eligible ☐ No insurance ☐ Underinsured (vaccines not covered by health insurance)
☐ Not eligible (vaccines covered by health insurance) ☐ Other state eligible

✓	Vaccine(s) to be given	Route[1]	VIS date[2]	Manufacturer[3]	Lot number	S/P[4]	Admin. site[5]	Person admin.[6]
	DTaP	IM		GSK SP				
	DTaP-HepB-IPV (Pediarix®)	IM		GSK				
	DTaP-IPV/Hib (Pentacel®)	IM		SP				
	DTaP-IPV (Kinrix®)	IM		GSK				
	Hepatitis A	IM		GSK MSD				
	Hepatitis B	IM		GSK MSD				
	Hep A-Hep B (Twinrix®)	IM		GSK				
	Hib (*H. influenzae* type B)	IM		GSK MSD SP				
	HPV2 or HPV4 or HPV9 *(circle)*	IM		GSK MSD				
	Influenza	ID/IM/IN						
	IPV	IM/SQ		SP				
	MMR	SQ		MSD				
	MMRV	SQ		MSD				
	Meningococcal Group B	IM		GSK PFZ				
	MCV4	IM		GSK SP				
	Pneumococcal Conjugate	IM		PFZ				
	Pneumococcal Polysaccharide	IM/SQ		MSD				
	Rotavirus	PO		GSK MSD				
	Td	IM		MBL SP				
	Tdap	IM		GSK SP				
	Varicella	SQ		MSD				
	Zoster	SQ		MSD				

Exemption or contraindication[7]:	**Date of exemption or contraindication:**

Signature and title of person administering vaccine:	**Date vaccine administered:**

1. **Route:** ID = Intradermal, IM = Intramuscular, IN = Intranasal, PO = Oral, SQ = Subcutaneous
2. **VIS date:** Document the publication date of the appropriate VIS. If VIS is given on a date other than the date of vaccination, also document the date VIS was given to patient or individual responsible for the patient.
3. **Manufacturer:** GSK = GlaxoSmithKline, MBL = Massachusetts Biological Laboratories, MSD = Merck & Co., PFZ = Pfizer, SP = sanofi pasteur
4. **Indicate if state-supplied or privately purchased:** S = State-supplied, P = Privately purchased
5. **Site Vaccine Given:** LA = Left Arm, RA = Right Arm, LT = Left Thigh, RT = Right Thigh
6. **Signature or initials of person administering vaccine:** Can be used if more than one person is administering vaccines
7. **Exemption or Contraindication:** MED = Medical, REG = Religious, PHIL = Philosophical, MOR = Moral, HOD = History of Disease (Please indicate date of exemption, contraindication or disease)